IN THE

Supreme Court of the United States

No. .....

THE COHEN, FRIEDLANDER & MARTIN COMPANY,
Petitioner,

vs.

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY,
Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES CIRCUIT COURT OF APPEALS FOR THE SIXTH CIRCUIT AND BRIEF IN SUPPORT THEREOF.

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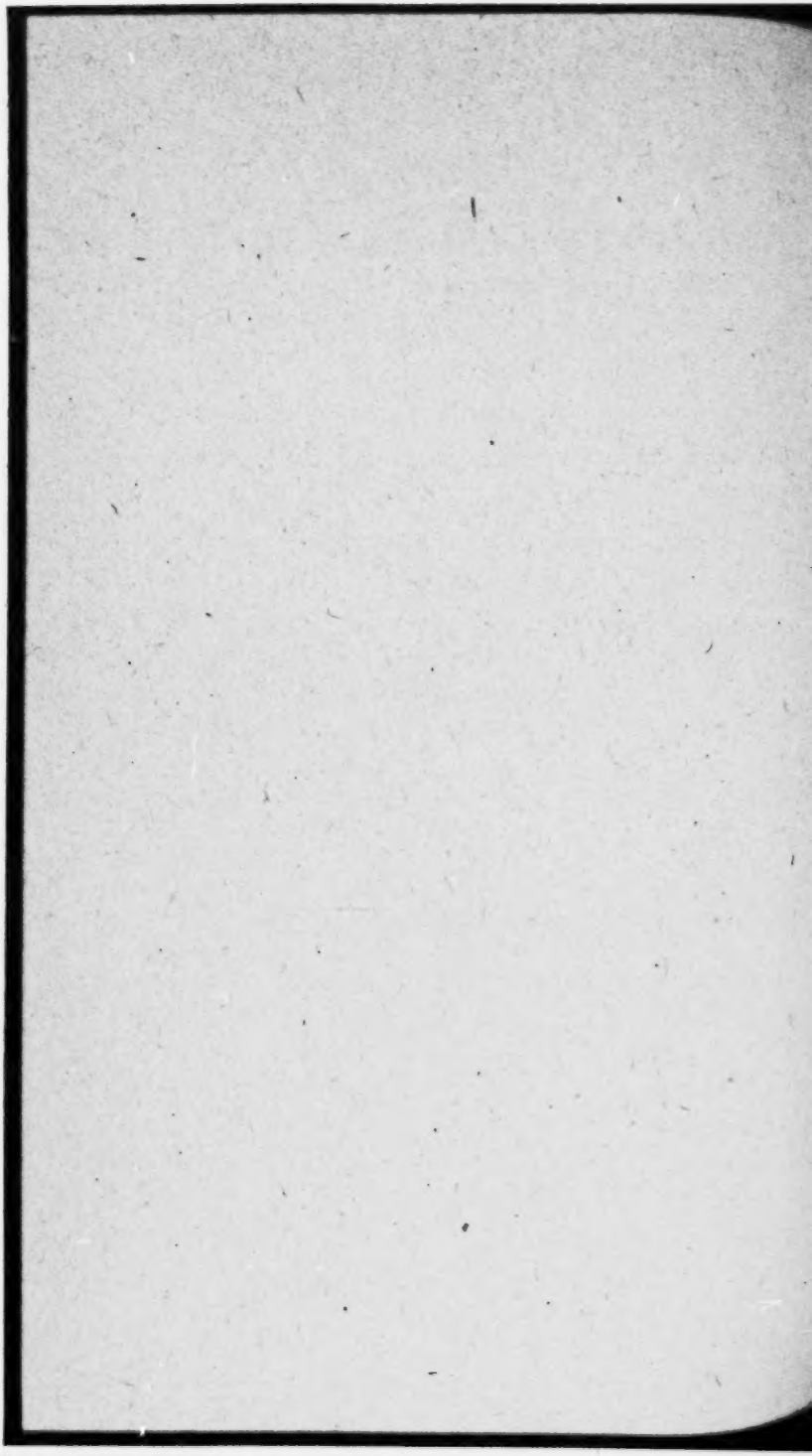

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PETITION FOR WRIT OF CERTIORARI

To the Honorable the Supreme Court of the United States:

Your petitioner respectfully shows:

I. SUMMARY OF MATTER AND QUESTIONS INVOLVED

The question decided below and presented here is one of law. The controlling facts are undisputed.

The District Court decreed cancellation of a life insurance policy issued by respondent under date of *August 10, 1945,* upon the life of Hyman Blitz, president of petitioner. Petitioner was the owner of the policy and entitled to the proceeds thereof. Petitioner's counterclaim for judgment on the policy was dismissed. The Circuit Court affirmed.

On August 29, 1945, Blitz and petitioner corporation made joint application to respondent for a policy on the life of Blitz (R. 50).

This application specified that the policy to be issued thereon was to be dated and issued as of "August 10, 1945" (R. 52).

In the application all questions relating to the assured's physical condition, including that of his heart, were truthfully answered.

On August 30 and 31, 1945, the assured was examined by two doctors employed by respondent insurance company. These physicians found no heart or health defects affecting his insurability and forthwith so reported to respondent (R. 80, 82).

The application contained no good health or similar clause. It was respondent's regular printed form and provided (R. 59):

> "If there has not been paid to the Company's agent the premium on the insurance herein applied for, such insurance shall not become effective until the Company has approved this application at its home office, the first premium has been paid and the policy delivered to me or to the owner designated therein *during my lifetime;* and that thereupon *the insurance shall become effective upon the date of issue stated in said policy.*"

In the event the premium was prepaid the application specified that the insurance "shall be effective from the date of the medical examination" provided the company approved the "application at its Home Office." (R. 59.)

The premium was not prepaid. It was paid on September 19, 1945, the date when the policy was delivered to petitioner.

The policy as delivered, conforming to the direction specified (R. 52) in the application, that it should be dated August 10th, provided on its face (R. 41):

> "Policy Year and Insurance begin August 10, 1945, which is the date of issue of this policy."

The policy also contained express clauses acknowledging payment of the first premium "in the manner requested in the application," providing that the premium was payable annually on or before the "10th day of each August," and stating that the policy and application "constitute the entire contract between the parties." (R. 41.)

The amount of the policy was $40,000.00. The annual premium therefor was $4,910.00. The first premium was applicable to and paid for coverage for the full year from August 10, 1945, the date when the *"insurance" began* and the *"date of issue"* of the policy.

On the night of September 11, 1945, Blitz suffered a severe heart attack and was hospitalized. He was, as petitioner was aware, in serious condition on the date the policy was delivered, namely, September 19, 1945. A little more than six months later, Blitz died as the result of another heart attack (R. 62).

As provided in respondent's application form, the application was approved at its home office, the policy was duly delivered, and the first premium was paid during the lifetime of Blitz.

The risk, therefore, attached and the insurance became effective on August 10, 1945, the date of issue stated in the policy.

Everything counted from that date. It established the anniversary on which future premiums must be paid. It fixed the time on which the insurance, paid for by the first premium, commenced. The risk of illness accruing after that date was upon the insurance company.

If this be not true, the application clause, "the insurance shall become effective upon the date of issue stated in the policy" is a snare and a delusion. What insurance? The risk of course as embraced in the policy which expressly stated that the "insurance" began "August 10, 1945."

Blitz had never had any heart ailment prior to September 11, 1945. The insurance company first learned of the attack which he suffered on that date from the proof of claim filed by petitioner with it after his death. This proof frankly and honestly stated that he had suffered a heart attack or "infarction" at that time (R. 72).

II. REASONS URGED FOR ALLOWANCE OF WRIT

Having in mind the fact that respondent by its own choice of words specified that the insurance began August 10, 1945, and in the application provided that "the insurance shall become effective" on that date, I contend:

(1) The failure of petitioner to advise respondent of a change in the assured's health after he was medically examined by the insurance company, and before delivery of the policy does not under the circumstances constitute fraudulent nondisclosure.

(2) Petitioner's officer who signed the application read the same. He was a layman. He did not have a lawyer at his side. He believed (R. 38, 39) and had a right to believe that his company was under no duty, after it and the assured had fully and honestly answered the questions contained in the application and the assured had been examined by two physicians for respondent, to advise the insurance company of a change of the assured's health pending delivery of the policy. Petitioner acted in good faith.

As was held by the Second Circuit Court of Appeals in the recent case of *Gaunt vs. John Hancock Life Ins. Co.*, 160 Fed. (2d) 599:

> "It is the understanding of persons unacquainted with the niceties of life insurance that counts in the construction of application and policy prepared by the company."

(3) If the language put in the application was ambiguous and might tend to lead a layman to believe there was no duty of disclosure, it must be construed most favorably to petitioner and most strongly against respondent.

(4) Section 9391 of the Ohio General Code provides:

> "No answer to any interrogatory made by an applicant, in his or her application for a policy, shall bar the right to recover upon any policy issued thereon, or be used in evidence upon any trial to recover upon such policy, unless it be clearly proved that such answer is wilfully false, was fraudulently made, that it is material, and induced the company to issue the policy, and that but for such answer the policy would not have been issued; and, also that the agent or company had no knowledge of the falsity or fraud of such answer."

The terms of this statute preclude the applicability to this case of the doctrine of "continuing representations." The answers in the application were true when made. How can a failure of petitioner to advise respondent of a change in the health of the assured make them "wilfully false" and "fraudulently made" when, as here, the application specifies that the insurance takes effect as of a prior date if certain things are done during the *lifetime* of the assured and not during his continued good health?

(5) The case of *Stipcich vs. Metropolitan Life Insurance Co.*, 277 U. S. 311 (held by the Circuit Court to be controlling) does not apply, (a) because there the application expressly provided that the company *would incur no liability* under it until the policy was delivered, (b) because said application did not provide that the insurance shall become effective on a prior date, (c) because the Ohio Statute above mentioned precludes reliance on the doctrine of continuing representations which was the basis of that decision, (d) the Stipcich policy was not dated prior to the change in health, (e) the Ohio rule stated in the syllabus

in the case of *New York Life Insurance Co. vs. Clutts*, 125 O. S. 555, requires the coverage under the policy here to run from its date of issue, namely, August 10, 1945, (f) the case of *Insurance Co. vs. Ford*, 2 O. App. 410, ignored by the Circuit Court, is a pertinent Ohio case and holds there is no duty on the part of an assured to make disclosure of a change in health pending delivery of his policy, (g) the *Stipcich* opinion expressly recognizes that under some circumstances, such as exist here, the parties are at liberty to contract exclusively on the basis of conditions as they exist as of a specific time, in which event failure to disclose later changes in health may not affect the policy, (h) the *Stipcich* decision should not be arbitrarily extended to apply to cases distinguishable from it on their facts.

(6) The insurance company when it drafted its form application knew that several courts, notably the Circuit Court of Appeals for the 9th Circuit in *New York Life Insurance Co. vs. Moats*, 207 Fed. 481, and the Supreme Court of Minnesota in *Ames vs. New York Life Ins. Co.* had held that applications similarly worded should be construed as relieving the assured of any duty of disclosure of a change of health.

(7) The Circuit Court ignored the controlling Ohio law and committed such obvious error as to call for the exercise of the supervisory powers of this court.

III. JURISDICTION

The date of the judgment to be reviwed is February 5, 1948, and the same is reviewable under Section 240(a) of the Judicial Code, U. S. C. A. Title 28, Section 347.

THE COHEN, FRIEDLANDER & MARTIN COMPANY,
Petitioner,

By GEORGE R. EFFLER,
Counsel for Petitioner.

BRIEF IN SUPPORT OF PETITION

THE OPINIONS BELOW

The opinion of the District Court is to be found at page 88 of the record and that of the Circuit Court, as yet unreported, is also in the record at page 106.

A. THE OHIO CASES

There are three Ohio cases which bear upon the issue here involved, namely, *New York Life Insurance Co., vs. Clutts,* 125 O. S. 555; *Duncan vs. John Hancock Insurance Co.,* 137 O. S. 441; and *Insurance Company vs. Ford,* 2 O. App. 410.

In the case of *New York Life Ins. Co., vs. Clutts,* 125 O. S. 555; decided by the Supreme Court of Ohio on June 15, 1932, the first paragraph of the *syllabus* is as follows:

> "Where a provision in an accident and death policy of insurance recites that it takes effect as of the 12th day of March, 1930, which provision appears immediately over the signature of the authorized officers of the insurance company, such policy becomes effective March 12, 1930, regardless of the date of delivery and of repugnant clauses contained in the application for insurance."

Incidentally, in the case of *Thackery vs. Helfrich,* 123 O. S. 334, 336, the rule was stated that:

> "This court adheres to Rule VI of the Rules of Practice of the Supreme Court (see Volume 122, Ohio State Reports lxvlll) and *announces the law only through the syllabi of cases* and through *per curiam* opinions."

The foregoing paragraph of the *Clutts'* syllabus is therefore the unequivocal law of Ohio as announced by its highest court. It requires that the policy involved in the

case at bar be effective from August 10, 1945, long before a change in the health of the assured. If it was then effective, the insurance company ran the risk of a change of health and the policy need only to have been delivered during the lifetime of Blitz as is the fact. There was no obligation to advise respondent that the assured suffered a heart attack. That was a risk which it expressly *assumed.*

In the *Clutts* case the policy contained a clause that "this policy takes effect as of the 12th day of March, 1930, which day is the anniversary of the policy."

The application specified that the insurance applied for should not become effective until the policy was delivered to and received by the applicant and the first premium paid, and then only if the applicant had not consulted or been treated by any physician since his medical examination.

The insurance company claimed that the policy was not delivered until March 17th, and that after the medical examination on March 7th, and before the policy was delivered, the insured had consulted and been treated by physicians for the illness which caused his death.

Significantly, it is said at page 557 of the opinion:

> "As this court views it, the insurance company has no standing whatever in this case. It undertakes to plead a violation of a clause of a provision of the application. This court is of the opinion that the facts in this case do not bring it within the provision of this clause, and if they did the beneficiary was entitled to a verdict in her favor for the full amount of the policy, *according to the terms of the policy.*
>
> The insurance company insists that the insured is charged with a complete knowledge of every provision contained in his application; that if, after he has been examined and made application for his policy, he is obliged to have medical attention, upon the delivery of the policy he must refuse to accept it and must direct the company to cancel it."

The court held the assured had no such duty because the policy by its very terms became effective on a prior date stated therein.

The case of *Duncan vs. John Hancock Life Ins Co.*, 137 O. S., 441 is pertinent. In that case the assured applied for a policy September 9, 1937. An advance of $1.00 against the first premium was paid with the application. The applicant was then given a form of receipt which contained the following provision as found in the opinion on page 443:

> "It is understood and agreed that no liability is assumed by the company on account of this payment nor until it shall issue a policy, but if death occurs after the date of the application from which this receipt is detached and prior to the date of issue of such policy, payment in accordance with and subject to the conditions and provisions of the policy applied for shall be made; provided the applicant is insurable under the company's rules and the application is approved and accepted by it at its home office as to plan, premium and amount of insurance."

The applicant for insurance became ill September 24, 1937, and died Sept. 29, 1937 before the application was accepted or approved by the company as to plan, premium or amount of insurance.

The Ohio Supreme Court held that the receipt was in the nature of a binder and the beneficiary named in the policy could recover thereon. At page 446 of the opinion the court says:

> "Appellant contends that from the above quoted language it may reasonably be inferred that the parties intended interim or temporary insurance to go into effect immediately upon the payment of the initial premium and issuance of the receipt; that the interim or temporary insurance thus effected was to be for the period between the making of the appli-

cation and its approval and acceptance or rejection by the insurer.

"Appellee, on the other hand, contends that both the application and the receipt expressly provided that there was to be no liability until a policy was issued unless the initial premium was paid at the time the application was signed, in which event payment would be made if death occurred prior to the issuance of the policy, and provided the application was accepted and approved at the home office as to plan, premium and amount of insurance; and that since the application was never accepted or approved by the company, it follows that no contract was ever made, and consequently liability does not arise.

"From the language 'provided the applicant is insurable under the company's rules and the application is approved and accepted by it (the company) at its home office as to plan, premium and amount of insurance,' it is possible to construe the meaning of the receipt to be that it was the intention of the parties that liability should not attach to the company unless the applicant was an insurable risk and until the application was approved and accepted 'as to plan, premium and amount of insurance.' Yet, from the language, 'but if death occurs after the date of the application * * * and prior to the date of issue of such policy, payment in accordance with and subject to the conditions and provisions of the policy applied for shall be made,' it is equally possible to construe the meaning of the receipt to be that it was the intention of the parties that liability should attach to the company if death should occur 'after the date of the application.' Otherwise, the words *'after the date of the application'* would be devoid of any meaning and would be superfluous.

"Were it the intention of the parties that liability should not attach 'after the date of the application' but should attach only after approval and acceptance and before the policy is issued, would not that language, or language of similar import, have been used? Surely the words 'after the date of the appli-

cation' were intended to have some meaning and binding force and effect. The provisions of the receipt are obviously ambiguous and susceptible of two different constructions. It was possible for the appellee, as composer of the provisions of the receipt, to have been clear and thereby to avoid ambiguity. 'An insurer will not be permitted to benefit from an ambiguity of his own creation.' *Copelin-Mohn, Inc., vs. Buckeye Union Casualty Co., supra,* at page 291.

"Under the rule of construction laid down in *Copelin-Mohn, Inc., vs. Buckeye Union Casualty Co., supra,* the ambiguity must be resolved against the author, the appellee herein, and the parties must be deemed to have intended that interim or temporary insurance should go into effect immediately upon the signing of the application and payment of the initial premium.

"Where a 'binding receipt' is issued by a life insurance company to an applicant, providing that no liability is assumed by the company on account of the initial premium payment 'nor until it shall issue a policy, but if death occurs after the date of the application * * * and prior to the date of issue of such policy, payment in accordance with and subject to the conditions and provisions of the policy applied for shall be made; provided the applicant is insurable under the company's rules and the application is approved and accepted by it at its home office as to plan, premium and amount of insurance,' the parties will be deemed to have intended to effect a present contract of interim or temporary insurance on the life of the applicant, to commence immediately upon the signing of the application and payment of the initial premium."

While the language construed in the *Duncan* case was contained in a "binding receipt" that fact is of no particular distinguishing significance because here the terms of the application as clearly constitute "interim insurance" as the terms of the receipt in the *Duncan* case.

In the *Ford* case (2 O. App. 410) the assured made application for a policy. He was thereafter examined by the company physician who reported his findings to the company. The company being satisfied with the examination, issued its policy and sent it to its agent for delivery. The agent found the assured ill with typhoid fever and refused to deliver the policy. The insured died four days later. It was held that there was a completed contract and that the insurance company was liable. The premium had been paid by a note to the agent.

With that state of facts before it the Court of Appeals of Geauga County in its opinion stated on page 418:

> "It is not claimed in this case that the assured was not in good health at the time he signed the application or at the time he was examined by the medical examiner of the company. It is not claimed that there was any misrepresentation made by him at any time. In the light of the authorities above cited, we do not think there was any fraudulent concealment.
>
> * * * To say that when he was taken ill on July 7, long after the application had been made, it was then his duty to make additional disclosures to the company as to the condition of his health, we think is not supported by any authorities cited by counsel for plaintiff in error, but is opposed to all the authorities we have been able to find."

The foregoing Ohio cases indicate the attitude of the Ohio Courts on issues similar to those involved in the case at bar and they clearly show that the delivery of a policy is not in any respect essential to the inception of the insurance risk, particularly where, as in the *Clutts* case, the effective date of the policy is antedated.

In the *Clutts* case the court said:

> "We are of the opinion that it makes little or no difference when this policy was delivered in view of these provisions."

In the *Ford* case there had been no delivery of the policy and in fact the insurance company had refused to make delivery thereof.

In the *Duncan* case death even occurred prior to the issuance and delivery of the policy.

In the case at bar there was a delivery of the policy, during the lifetime of the assured, within the purview of terms of the application.

B. THE OHIO STATUTE, SECTION 9391, GENERAL CODE

There is another matter which, in my opinion, has a direct bearing on the issues in this case. *Section 9391 of the Ohio General Code* provides as follows:

> "Sec. 9391. WHEN FALSE ANSWER MATERIAL. No answer to any interrogatory made by an applicant, in his or her application for a policy, shall bar the right to recover upon any policy issued thereon, or be used in evidence upon any trial to recover upon such policy, unless it be clearly proved that such answer is wilfully false, was fraudulently made, that it is material, and induced the company to issue the policy, and that but for such answer the policy would not have been issued; and, also that the agent or company had no knowledge of the falsity or fraud of such answer."

Now applying the foregoing code provisions to the situation here presented, what do we find?

The insurance company in its complaint recites that the insured, in his application, made numerous statements regarding his condition of health and, among other things, represented that he had no heart disease. It is further alleged that these representations were "continuing representations," were material to the risk and were relied upon by the insurance company at the time of the delivery of the policy. (R. 3.)

No claim whatsoever is made by the insurance company that the answers in the application were not true when made.

Under the terms of the statute, the answers in the application shall not bar the right of recovery upon the policy issued thereon, unless it be proved clearly that such answers are wilfully false and fraudulently made.

If these answers were true when they were made, as is the fact, how can a failure on the part of The Cohen, Friedlander and Martin Company to advise the insurance company of a change in Blitz's state of health make them wilfully false and fraudulent particularly where, as here, the policy contains a provision that it shall take effect as of its issue date, when certain conditions have been complied with during the lifetime of the assured.

The failure on the part of the defendant company to disclose the fact that Blitz had suffered a heart attack and was in a hospital at the time of the delivery of the policy was justifiable. The defendant company had every reason to believe it was under no duty to make such disclosure. If, relying on such belief, it did not communicate Blitz's change of health to the insurance company, that failure on its part can not render false and fraudulent answers in the application which were absolutely true when they were given. The representations in the application, therefore, can not be treated as continuing representations.

From an examination of the Statute, it will be seen that the answers in the application *can not even be used in evidence* as a defense by the insurance company unless such answers are wilfully false and are fraudulent and material. The answers in the application here were all true when made so that they can not be treated as in evidence for the purpose of claiming that they constituted continuing representations. So far as the situation in the case at bar is concerned, the applicant made complete and full disclosure of

all facts and conditions affecting the risk in his application and the insurance company based the issuance of its policy and accepted the risk as of August 10, 1945 upon a consideration of this application and the complete reports made by its two medical examiners.

This statute effectively disposes of any claim in the complaint filed by the respondent that the doctrine of continuing representation has application here. The statute also effectively removes from the case any contention that the holding in the *Stipcich* case (hereinafter referred to) on the doctrine of continuing representation has application in this state to a factual situation such as is now before the court.

C. THE STIPCICH CASE IS NOT CONTROLLING

The Stipcich case—*Stipcich vs. Metropolitan Ins. Co.*, 277 U. S. 311—is based on a policy which by its very terms precluded liability under the facts there involved. The application there stated that *"the company shall incur no liability"* until the application is approved "and a policy issued and delivered" to applicant and the "first full premium" paid and "accepted" by the company.

Nowhere in the Stipcich policy is there any provision as there is here that "the *insurance* shall become effective upon a prior date, namely, the date of issue stated in the policy." Nor was the policy there dated before a change had occurred in the health of the applicant.

What does the clause mean in the present policy that "the *insurance* shall become effective on August 10, 1945," a full month before Blitz suffered any change in his condition of health? The word insurance implies protection on the one side and obligation and risk on the other. It indicates the commencement of the risk and its continua-

tion during the entire year for which the premium is to be paid—namely, August 10, 1945, to August 10, 1946, provided only that the application was approved, the policy delivered and the first premium was paid while Blitz was in full life.

In the *Stipcich* case the court said (page 315):

> "An insurer may, of course, assume the risk of such changes in the insured's health as may occur between the date of application and the date of issuance of a policy. Where the parties contract exclusively on the basis of conditions as they existed at the date of the application, the failure of the insured to divulge any later known changes in health may well not affect the policy. *Mutual Ben. L. Ins. Co. vs. Higginbotham,* 95 U. S. 380, 24 L. Ed. 499; see *New York L. Ins. Co. vs. Moats,* 125 C. C. A. 143, 207 Fed. 481; *Grier vs. Mutual L. Ins. Co.,* 132 N. C. 542, 44 S. E. 28; compare *Gardner vs. North State Mut. L. Ins. Co.,* 163 N. C. 367, 48 L. R. A. (U. S.) 714, 79 S. E. 806, Ann. Cas. 1915 B, 652."

This quotation indicates most clearly that the decision was not intended to apply in those cases where the insurance company assumes the risk of a change of health on the part of the assured prior to the issuance and delivery of the policy. The cases cited by the court are discussed hereinafter. They demonstrate that the *Stipcich* case was not intended to apply to a case *where as here the policy went into effect as of a date specified by the insurance company which antedated a change in health of the assured* and *where as here the first premium paid for protection from* the *stated effective date of the insurance.*

In *John Hancock Mut. Life Co. vs Luzio,* 123 O. S. 616 (a case relied on by the District Court as approving in Ohio the application of the law as stated in the *Stipcich* case) the policy contained a *sound health clause* and also *expressly provided that the policy should be void if within*

two years before the date thereof the assured suffered from any pulmonary disease. The assured, on December 26, 1928, twenty days before his death, secured two policies of industrial life insurance which were issued without a medical examination being required. Luzio had been under treatment for tuberculosis from November 4, 1927, more than a year before the issuance of the policies and his condition was diagnosed as advanced bilateral pulmonary tuberculosis, involving the upper left lobe with lung destruction and cavity formation. Luzio also had syphilis prior to his application for the policies in question.

As stated by the Supreme Court of Ohio (page 620):

> "The whole case as disclosed by this record hinged upon the issue whether one Cugliari, a soliciting agent of the insurance company, knew that the insured was not in sound health and that he had been in a tuberculosis hospital under treatment of a physician for that disease when he solicited the policies."

The court found that Luzio and the soliciting agent connived together to defraud the insurance company and held, therefore, that there could be no recovery.

There was no issue before the court as to nondisclosure after the application was made and before delivery of the policy. The matter of nondisclosure had to do solely and only with the facts sought to be elicited in question and answer form in the application itself.

With that factual information before it, the Ohio court referred to the *Stipcich* case as sustaining its position that the assured was required to exercise good faith in respect to his soundness of health and was required to disclose facts and conditions in his application, of which he was aware, materially affecting the risk.

It will be seen, therefore, that the *Luzio* case does not bear the slightest similarity to the case at bar.

D. GENERAL AUTHORITIES AND DECISIONS FROM OTHER JURISDICTIONS

Let us now look at some of the other cases which bear upon the issue before the court. A similar situation to that here involved was before the Minnesota Supreme Court in the case of *Ames vs. N. Y. Life Insurance Company*, 191 N. W. 274. There had been no delivery of the policy in that case before a serious illness of the applicant occurred. The court specifically held that delivery was unnecessary to assumption of the risk by the insurance company of a change of health. We quote from the opinion as follows:

> "After the application was accepted and the policy issued, but *before it was delivered and before the first premium was paid*, the insured became seriously ill. In ignorance of the fact, the policy was delivered and a check for the premium received. It is held, that the policy could not be avoided on the ground that the insured, or his representative, was bound to disclose the change in his physical condition and wrongfully failed to disclose it."

In the *Ames* case, the court said:

> "By the terms of the application, the policy was not to take effect unless the first premium was paid and the policy delivered during the *lifetime* of the applicant."

At *page 276*, the Minnesota Supreme Court, with the foregoing situation before it, says:

> "But if we gave effect to the doctrine upon which appellant relies, would the conclusion follow that, under the circumstances in the present case, the applicant or some one in his behalf should have given immediate notice of his illness so that delivery of the policy might be delayed until the final outcome of his illness was known? Or was it the duty of the respondent to return the policy because her husband

was on his death bed when it came into the hands of his agent? We think not. Unlike most of the cases in which the doctrine has been asserted, the negotiations between the parties were no longer pending and no deception was practiced to get possession of the policy. Appellant and its agents were the actors. Uninfluenced by anything said or done by the applicant or his agents, without inquiry, and of its own motion, it delivered the policy and called for and received the premium. It is difficult to spell out fraud from anything that was said or done or left unsaid or undone. We reach the conclusion that, viewed from any standpoint, the evidence fails to show that the applicant, or anyone representing him, was guilty of sharp practices of any kind, entitling appellant to avoid the contract."

The 6th paragraph of the syllabus, in the case of *N. Y. Life Ins. Co. vs. Moats*, (C. C. A. 9) 207 Fed. 481, cited by the court in the *Stipcich* case, is as follows:

"Where an application for a life insurance policy stipulated *that it should not take effect until the premium was paid and the policy delivered, but then it should relate back to the date of the application, and the policy provided that it should take effect as of the date of the application, upon payment of the premium and delivery,* and neither the application nor the policy contained a provision that the insured should be in sound health when the policy was delivered, the fact that insured did not, of his own volition, without inquiry from the company, inform it when the policy was delivered that he had been confined in a sanitarium since his application was made was not a fraud upon the company which would vitiate the policy."

At *page 492* of the opinion, the following is found:

"The express proviso in the application that upon payment of the first premium, and upon delivery to and receipt by the deceased of the policy during his

lifetime, *the policy should then relate back to take effect as of the 16th day of March, 1911, and the express proviso in the policy itself that upon such delivery and receipt it should take effect as of the 16th day of March, 1911, are sufficient to firmly establish the terms of the contract that, those conditions being complied with, it was the intention of the parties that the policy was to take effect as of the 16th day of March, 1911.* A change in the health of the insured, in the absence of any proviso in the policy, or in the application therefor, that such change would avoid the policy, cannot vitiate it, nor divest the beneficiary of his rights thereunder. *That risk was one which the company had assumed by its contract, and for which it had been paid in the first premium.*

Nor can we agree with counsel for the insurance company that the representations contained in the application for insurance were continuing representations, and were intended to cover the period between the date of the application and the date of the delivery to and receipt by the deceased of the policy. *We think that the doctrine of continuing representations is eliminated from this case by the express provisos contained in the application for insurance, and in the policy, that upon payment of the first premium, and upon delivery to and receipt by the deceased of the policy during his lifetime, the policy should then relate back to and take effect as of the date of the application.*"

We also quote from the opinion at *page 495*:

"We are of the opinion that the insurance policies in this consolidated case took effect on March 16, 1911, and covered the entire period from that date up to the death of the insured, and that whatever change, if change there was, in the health and physical condition of the insured prior to the delivery of the policies to the insured on April 16, 1911, was a risk within the terms of the policies, and that the insurance company is liable on its contracts."

The case of *Grier vs. Mutual Life Ins. Co.*, 44 S. E. 28 (North Carolina), is also in point. In the *Grier* case, which was cited in the *Stipcich* case, the policy and the application provided that if the application is approved and the policy issued, it shall be in force from the date of the application. It was held that the issuance of a policy is an acceptance of the application and should be based on the status at the time of the making of the application and is not affected by a subsequent change of health. Speaking of the provision in the policy as to the date on which it was to become effective, the court said, at *page 29*:

> "The same rule applies to the stipulations in the application which provide that the contract shall not take effect till the first payment shall have been made during continuance in good health. The application recites that the agent has given the insured a binding receipt, 'signed by the secretary of the company, making the insurance in force from this date, provided this application shall be approved and the policy signed by the secretary at the head office of the company and issued.' It was agreed thereby that, *if the application was accepted and the policy issued, the insurance began from the date of the application. Everything counted from that date, which is the anniversary on which future premiums must be paid, or the policy forfeited for non-payment. The risk of illness accruing after said date was upon the company from its acceptance of the application and 'issuance' of the policy.*"

In the case of *Watson vs. Metropolitan Ins. Co.*, 21 Atl. (2d) 503 (Pa., 1941), the deceased signed an application for insurance August 24, 1936. He was medically examined August 27, 1936. The policy was dated September 3rd and was delivered September 29, 1936. The premium was not paid until September 28, 1936, at which time a receipt evidencing payment was issued.

On September 27th, the deceased became ill and died on September 29, 1936. The defendant appealed from a judgment in favor of the plaintiff beneficiary under the policy and contended that the representations in the application were continuing. Paragraph 4 of "Part A" of the application contained the following:

> "That the company shall incur no liability under this application until it has been received, approved, and a policy issued and delivered, and the full first premium stipulated in the policy has actually been paid to and accepted by the Company during the lifetime of the applicant, *in which case policy shall be deemed to have taken effect as of the date of issue as recited on the first page thereof.*"

At page 507 of the opinion the court says:

> "Furthermore, the policy expressly provided: 'This policy and the application therefor, a copy of which is attached hereto as a part hereof, constitute the entire contract between the parties.' *And that means the application as signed, not as attempted to be altered and extended by the doctrine of 'continuing representation,' which would, in effect, alter the date of signing so as to make it read 'Sept. 28, 1936, instead of August 24, 1936' and August 27, 1936.*"

In *Couch on Insurance, Sec. 777,* we find the following:

> "And it is the well settled doctrine of this country that if the contract is so far completed that the company may be held to have assumed the risk, and a death or loss occurs *before the policy is delivered,* or, in some cases *even before the premium is paid,* no duty rests upon the party entitled to the benefit of the insurance to disclose the fact."

Again in *Couch on Insurance, Section 1328,* the following pertinent text is found:

> "Although a *policy may by agreement be antedated and take effect from that date or the parties*

may expressly contract that when certain acts have been performed the policy shall become effective as of a certain stipulated date, or a future date on which the policy is to become effective may be fixed, *in the absence of a special agreement, the parties in such case run the risk of conditions changing and thus affecting the situation when the term begins* * * * and as a policy is presumed to attach from the day of its date, the risk may attach before the delivery of the policy, as where it is not delivered until several days after it is dated. Again an accident insurance policy takes effect from its date, unless it is otherwise stated that it shall take effect only upon certain stated conditions, and if such conditions are met, and the policy delivered, it takes effect as of the day of its date."

E. ANY AMBIGUITY IN THE APPLICATION AND POLICY HERE MUST BE RESOLVED IN FAVOR OF DEFENDANT.

The Supreme Court of Ohio, in the case of *National Life & Accident Ins. Co., vs. Ray,* 117 O. S. 13-32, said:

> "Insurance policies, like other written contracts, mean what they say and all they say. They are written for the protection of both parties thereto, and all others interested in the policies. If such contracts are not to be enforced as written, they might as well not be written at all."

Now, why did Massachusetts Mutual Life Insurance Company specify in its application form that the *insurance* should be effective on August 10, 1945, if the application was approved, the policy delivered and the first premium paid during Blitz's lifetime?

Why did it specify that the "policy year and *insurance begin*" August 10, 1945? What does the word "begin" mean?

It could as well have said that the policy became effective if delivered while Blitz was in good health, or only

if he had not consulted a physician between the date of application and the date of delivery, or it could have used some similar condition such as is frequently written into policies by insurance companies.

The specific language of the policy is significant. And the omission of a good health or similar clause is likewise significant.

The risk here attached and dated from August 10, 1945, regardless of a change of health, upon the fulfillment of the other conditions. The insurance company assumed the risk of a change of health and intended so to do. The language in the policy and application can not be reconciled with any other interpretation.

It is high time that this insurance company is made to live up to the fine print in its application and policy forms.

No doubt, the insurance company and its salesmen make capital of the fact that its insurance plan is a liberal one and that it takes the chance that the assured will suffer a change of health between the date of its medical examination and the date of delivery and first premium payment.

If the premium is paid in cash at the time of the application, under the terms of this insurance contract, the company even insures against *death* between the time of the medical examination and the delivery of the policy. The only difference is that where the first premium payment is deferred, it must be paid, the application must be approved and the policy must be delivered while the assured is *alive*. Then the *insurance begins* as of a prior date.

If there is any ambiguity in the policy it must be resolved in favor of the assured.

Under these circumstances, petitioner, being fully aware of the terms of the application and of the risk assumed by respondent, conceived, and rightfully so, that it was under no duty to make any further disclosure regarding the assured's health before or at the time the policy

was delivered and the premium paid. There could not, therefore, have been any fraudulent concealment and the representations in the application cannot be regarded as continuing.

In the case of *Manufacturer's Acc. Ins. Co. vs. Dorgan*, 58 Fed. 945, Judge Taft, then sitting on the Circuit Court of Appeals for the Sixth District said at page 596 of his opinion:

> "It is a well settled rule in the construction of insurance policies of this character, which the insured accepts for the purpose of covering all accidents, to construe all language used to limit the liability of the company, strongly against the company. Policies are drawn by the legal advisors of the company, who study with care the decisions of the courts, and, with those in mind, attempt to limit as narrowly as possible the scope of the insurance."

When the insurance company specifically provided in its application that the insurance should become effective on the date of issue stated in the policy and application, if the application was approved during Blitz's lifetime and the first premium was paid and the policy delivered while Blitz was alive, it knew that Blitz, when he signed this application, would read it and it knew also that when Mr. L. C. Remdt, the treasurer of The Cohen, Friedlander and Martin Company, signed this application, he likewise would read it.

The insurance company also knew that anyone who read the application would immediately assume that after the applicant was examined medically by the company, the company took the risk that his health would not change until the policy was delivered and the first premium thereon was collected.

In the case of *Aschenbrenner vs. United States Fidelity and Guaranty Co.*, 292 U. S. 80, the court at the bottom of page 84 of the opinion says:

> "The phraseology of contracts of insurance is that chosen by the insurer and the contract in fixed form is tendered to the prospective policy holder who is often without technical training, and who rarely accepts it with a lawyer at his elbow. So if its language is reasonably open to two constructions, that more favorable to the insured will be adopted."

Now having in mind cases like that decided by the Ninth Circuit Court of Appeals in *New York Life vs. Moats*, 207 Fed. 481, and the Supreme Court of Minnesota in *Ames vs. N. Y. Life Ins.*, 191 N. W. 294, we call attention to the following pertinent quotation from the opinion in the case of *Minnesota Mutual Life Ins. Co. vs. Marshall*, 29 Fed. 2d 977 (C. C. A. 8) 978:

> "It is unnecessary to attempt to distinguish the language of the policies upon which these differing opinions are based. They unquestionably put a different construction upon practically the same provisions of insurance policies. They differ as to the construction of the same or similar language. *These decisions of themselves establish doubt as to the construction and meaning of the provisions which we are called upon to interpret.* It is a familiar rule of construction that where contracts of insurance are prepared by the insurer and there is doubt as to the meaning of their provisions, it will be construed most favorably to the insured.
>
> It is said that compliance with this provision, even though impossible, was a condition precedent to the securing of insurance. But narrow and unreasonable interpretations of clauses in an insurance policy are not favored. They are prepared by the insurer and if, with equal reason, open to two constructions, the most favorable to the insured will be adopted." *Josephine Stipcich vs. Metropolitan Life Ins. Co.*, 277 U. S. 311, 48 S. Ct. 512, 72 L. Ed. 895.
>
> Forfeitures are not favored: "The rule is that if policies of insurance contain inconsistent provisions or are so framed as to be fairly open to constructions,

that view should be adopted, if possible, which will sustain rather than forfeit the contract." *McMaster vs. New York Life Ins. Co.*, 183 U. S. 25, 22 S. Ct. 10, 46 L. Ed. 64.

Inasmuch as the "Policy and Insurance *begin* August 10, 1945, which is the date of issue" of the policy and inasmuch as the insurance contract provided that if during Blitz's lifetime the application was approved, the policy delivered and the premium paid "*thereupon* the insurance shall become effective upon the date of issue stated in said policy" it is clear that the first premium paid for protection for the full year from August 10, 1945, to August 10, 1946.

Any layman, and indeed any lawyer, would be justified in so concluding.

What good could be accomplished by making the insurance effective as of the date of issue of the policy if it did not cover a change of health? What could such insurance cover? If there were no change in health during that period the coverage, while paid for, would be meaningless. When did the insurance begin if not on the date specifically stated by the company in its contract?

The insurance protection bought and paid for consisted of this—that if Blitz was found to be in good health by the company medical examiners, then the company assumed the risk of a change in health prior to delivery of the policy.

If this were not true the words "*insurance begin*" and "the *insurance* shall become effective" on the date of issue are meaningless and superfluous.

Also it should be borne in mind that the annual premium for this policy was $4,910.00 so that the *insurance company received in excess of $500.00 for its acceptance of the risk* prior to delivery of the policy.

F. PLAINTIFF INTENDED THAT IT SHOULD ASSUME THE RISK BEFORE THE POLICY WAS DELIVERED.

In the case of *Subar vs. N. Y. Life Ins. Co.*, 60 Fed. 2d 239 (C. C. A. 6), Judge Moorman speaking for the court said at page 240:

> "A contract of insurance, as has been frequently held, rests upon and is controlled by the same principles of law applicable to other contracts, and the parties may stipulate and agree that it shall be effective at a given time, or upon the happening of a designated event, or shall not be effective at all if there occurs a specified intervening event."

In the case of *Commercial Mutual Marine Ins. Co. vs. Union Mutual Ins. Co. of N. Y.*, 19 Howard 318, it was held:

> "Whether the risk shall commence from a past day, depends on the terms of the contract."

And in the opinion of this court in the case foregoing, the following quotations have application to the case at bar:

> "Their fair meaning is, that though he had agreed to make the insurance, as the secretary and clerks were not there, and the books not accessible, any action on the agreement must be deferred to the next day. The words cannot be understood to mean that he would on the next day attend to what he had already done; and he had already made a contract for reinsurance, to be executed on the next day, by issuing a policy in due form to carry that agreement into effect.
>
> *Where, as in the present case, there is an express contract to take the risk from a past day, there is no room for any understanding that it is not to commence until a future day. Such an understanding would be directly repugnant to the express terms of the contract.*
>
> Nor do we deem it essential to the existence of a binding contract to make insurance, that a pre-

mium note should have been actually signed and delivered. The promise of the plaintiffs to give a note for the premium was a sufficient consideration for the promise to make a policy. It is admitted that the usage is to deliver the note when the policy is handed to the assured. If the defendants had tendered the policy, we have no doubt an action for not delivering the premium note would have at once lain against the plaintiffs; and we think there was a mutual right on their part, after a tender of the note, to maintain an action for non-delivery of the policy. In *Taylor vs. The Merchants' Fire Ins. Co.*, 9 How. 390, it was held that a bill in equity for the specific performance of a contract for a policy could be maintained. And it being admitted that in this case the defendants would be liable as for a total loss on the policy, if issued in conformity with the contract, no further question remained to be tried, and it was proper to decree the payment of the money, which would have been payable on the policy, if it had been issued."

The first and fourth paragraphs of the syllabus in the case of *Schwartz vs. Northern Life Ins. Co.*, 25 Fed. 2d 555 (C. C. A. 9), read as follows:

"1. The date from which a policy of insurance becomes effective is not necessarily determined by the date which it bears, or the date of its execution or delivery, or by date when first premium is paid, but it is the date from which the risk commences, determined by the meaning of the provisions of the contract.

4. Effect will be given to an agreement that life insurance policy shall be dated as of the date of the application and relate back to and take effect from that date."

At *page 557 of the opinion* the court says:

"The principal question presented in the case is upon what date the policy became effective. The

appellant says it was August 2, 1924. The appellee says it was August 14, 1924. The date from which a policy becomes effective is not necessarily determined by the date which it bears or the date of its execution or the date of its delivery or by the date when the first premium is paid. It is the date from which the risk is commenced, and it is determined by the meaning of the provisions of the insurance contract. *Mutual Life Ins. Co. of New York vs. Hurni Packing Co.*, 263 U. S. 167, 44 S. Ct. 90, 68 L. Ed. 235, 31 A. L. R. 102. Said the court in that case, page 175 (44 S. Ct. 91): 'It was competent for the parties to agree that the effective date of the policy should be one prior to its actual execution or issue; and this, in our opinion, is what they did.' "

And we find the following at *page 558 of the opinion*:

"From a consideration of all the provisions of the contract here in question, we reach the conclusion that the minds of the contracting parties met in fixing upon August 2, 1924, as the date from which the policy became effective and as the date upon which the risk commenced and the date from which began the year during which the policy might be contestable for suicide. It was for a year commencing with that date that the insured paid the premium, and August 2nd was made the date of the payment of each annual premium thereafter and the date upon which the appellee's reinsurance in another company took effect."

When Massachusetts Mutual Life Insurance Company prepared the application and the policy here involved it did not do so in a haphazard fashion. Obviously, the words and clauses used therein were given considerable thought. Also, the insurance company gave considerable thought to the probable construction of the meaning of the various provisions in its application and policy.

One need but to look at the many reported cases in federal courts and also in the state courts to find that

many insurance companies, for their own protection and so that the applicant or assured will not be misled, insert clauses to the effect that the policy will not become effective unless delivered to the assured while he is in good health or while he is in the same state of health as when examined by the company physicians or while he is in a state of continued insurability.

No one can be so naive as to suppose or claim that Massachusetts Mutual Life Insurance Company, one of the largest companies in the business, did not carefully consider in the drafting of its application and policy the inclusion of such a clause therein. Nor can any one be so naive as to believe or contend that the omission was not intentional and purposeful.

This insurance company has a legal department and it is inconceivable that its insurance library does not contain ready references to all the reported cases dealing with life insurance. The drafters of this policy, no doubt, were fully conversant with cases such as *Ames vs. New York Life Insurance Co.*, 191 N. W. 274, and *New York Life Insurance Co. vs. Moats*, 207 Federal 481, wherein the courts, considering applications in somewhat similar form as that here utilized, held that there was no duty on the part of the applicant to advise the insurance company of a change in health between the date of medical examination and the date of delivery of policy.

CONCLUSION

It is my contention, as earlier stated, that the application and insurance contract are determinative of the issues before the court. Under this application and contract the insurance company agreed that if certain things were done during the lifetime of Mr. Blitz, the *"Insurance"* should take effect and *begin* on the date of issue stated in the policy, namely, *August 10, 1945.* The things necessary to be done during his lifetime, in order to make the effective date of the insurance coverage relate back to August 10th, were three in number:

1. Payment of the premium during his lifetime;
2. Delivery of the policy during his lifetime;
3. Approval of the application at the home office of the company during his lifetime.

All of these three things were done while Blitz was in full life.

The policy expressly provides on its face:

> *"Policy year and insurance begin August 10, 1945,* which is the date of issue of this policy."

True, Blitz had suffered a heart attack before the policy was delivered, before the first premium was paid and before the application was approved. It is true also that the fact that he had suffered this heart attack was not communicated to the insurance company. But, as I have pointed out above, the specific terms of the policy do away with any duty of advising the insurance company that there had been a change in Blitz's health.

The secretary and treasurer of petitioner signed the application, which contained the proviso that if the three things mentioned above were accomplished during the assured's lifetime, then the policy should take effect on August 10th, the date of issue therein stated. Having read

this provision, which the insurance company itself wrote into the application, he justifiably believed that he was under no duty of disclosure whatsoever. As he read the contract, the insurance company was dealing with his company on the basis of Blitz's condition as of the date of the policy, providing that during Blitz's lifetime the application was approved, the policy delivered and the first premium paid. The insurance company agreed that its contract became effective as of August 10th and assumed the risk of a later change in the health of the assured for which it received over $500.00, being that portion of the premium of $4,910.00 allocable to the period prior to delivery of the policy.

I respectfully submit, therefore, that the Petition for Certiorari should be granted.

GEORGE R. EFFLER,
Counsel for Petitioner.

IN THE

Supreme Court of the United States

October Term, 1947

No. 743

THE COHEN, FRIEDLANDER & MARTIN COMPANY,
Petitioner,

vs.

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY,
Respondent.

BRIEF OF RESPONDENT IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES CIRCUIT COURT OF APPEALS, FOR THE SIXTH CIRCUIT.

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THE COHEN, FRIEDLANDER & MARTIN COMPANY,
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BRIEF OF RESPONDENT IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES CIRCUIT COURT OF APPEALS, FOR THE SIXTH CIRCUIT.

STATEMENT OF CASE

1. Nature of Case and What Happened Below

Respondent, Massachusetts Mutual Life Insurance Company, filed suit in the Northern District of Ohio, Western Division, to cancel a policy of insurance issued to petitioner, The Cohen, Friedlander & Martin Company, upon the life of its president, Hyman Blitz (R. 2).

The trial court, the Honorable Frank L. Kloeb, Judge, decreed cancellation as prayed for in the complaint (R. 100); and upon appeal by petitioner, the United States

Circuit Court of Appeals, for the Sixth Circuit, affirmed (R. 105).

Findings of fact and conclusions of law were duly made and entered by the trial court (R. 93).

2. Opinions in the Courts Below

The written opinion of the trial court is in the record at page 88 and is officially reported in 70 F. Supp. 186; that of the Circuit Court of Appeals is in the record at page 106 and is officially reported in 166 F. 2d 63.

3. Material Provisions of the Application

The application, which was to constitute a part of the policy when issued, was signed by both the petitioner as beneficiary-owner and Blitz as insured (R. 50, 53); and petitioner expressly ratified insured's "representations, statements, answers and agreements contained in Parts 1 and 2 of this application" and agreed to be bound thereby (R. 52).

The material provisions of the application are the following:

> "Have you had at any time
>
> 3. A. Pain, pressure or discomfort in the chest, shortness of breath, palpitation, or any disease of the heart?
>
> No.
>
> • • • •
>
> F. Any serious illness, disease, or injury other than those mentioned, or ever undergone any surgical operation?
>
> No." (R. 54.)
>
> "I understand and agree that:
>
> 1. This application consisting of Parts 1 and 2 taken together shall form the basis of the contract

applied for and shall become a part of said contract when issued.

2. If there has not been paid to the Company's agent the premium on the insurance herein applied for, such insurance shall not become effective until the Company has approved this application at its Home Office, the first premium has been paid and the policy delivered to me or to the owner designated therein during my lifetime; and that thereupon the insurance shall become effective upon the date of issue stated in said policy." (R. 56.)

4. Statement of the Facts

Although the salient facts are set out in the findings of fact of the trial court (R. 93), and in the opinions of the trial court (R. 88) and the Circuit Court of Appeals (R. 106), it may be helpful to state them here in a little more detail, since the statement in petitioner's brief is incomplete.

On August 29, 1945, petitioner joined with Hyman Blitz, its president, in an application to the respondent for a policy of insurance in the amount of Forty Thousand Dollars ($40,000) upon the life of Blitz, in which petitioner was to be beneficiary and owner (R. 50).*

The petitioner *did not prepay* the premium; in fact, the premium was not paid until the policy was delivered on September 19th, a week after Blitz had been stricken with a critical heart attack (R. 67).

On August 30, 1945, and August 31, 1945, two physicians, each acting for the respondent, made medical examinations in Toledo of Hyman Blitz. Those examinations

* In addition to these references to the record, it may be noted that all exhibits referred to in this brief were received in evidence at one time (R. 12).

failed to disclose any disease of the heart or other physical conditions fatal to his insurability (R. 53-60). The application, showing the results of these examinations, was forwarded to the Home Office of the respondent in Springfield, Massachusetts.

In due course the application was referred to Mr. Michael Marchese, assistant secretary of the respondent in charge of its underwriting department, and Dr. Howard Brown, its associate medical doctor, for examination and approval, or disapproval (R. 19, 26). Dr. Brown caused certain inquiries to be addressed to Dr. A. A. Applebaum, of Toledo, with whom Hyman Blitz had consulted from time to time and whose name appeared in the application as having made periodical health examinations of Hyman Blitz (R. 19, 20, 75). Mr. Marchese initiated inquiries concerning the aviation habits and intentions of Hyman Blitz (R. 26, 77, 78). These inquiries developed no facts indicating that Hyman Blitz was unacceptable as an insurance risk.

Mr. Marchese and Dr. Brown completed their investigations on or about September 17, 1945, and relying upon the statements contained in the application and the negative results of their inquiries, approved the application on that date; and the policy was issued and mailed the same day to the respondent's general agent in Toledo, Frank O. D. White, for delivery to the petitioner (R. 21, 26, 27, 76).

The policy having arrived in the offices of the general agent on September 18th or 19th, it was given to Irving E. Goldman, the soliciting agent, for delivery. On September 19th, Mr. Goldman took the policy to the petitioner's offices in Toledo and there delivered it to the petitioner by handing it personally to Lyle C. Remdt, the secretary and treasurer of the company, and the officer charged by the petitioner with the duty of arranging for and carrying out the details in connection with the procurement of the

policy. Mr. Remdt immediately caused the company's check for the first year's premium in the amount of $4,910 to be issued and delivered to Mr. Goldman, at the same time accepting delivery of the policy (R. 66, 67).

During the period from August 31st to September 19th, while the application was being checked at the home office, there occurred events which, upon their face, demonstrated the complete lack of insurability of Hyman Blitz. On September 9, 1945, Hyman Blitz consulted with J. B. Hirsch, M. D., of Toledo (R. 16). Immediately following that consultation he went to New York City and on September 12, 1945, at about 2:30 o'clock a. m., suffered an acute heart attack, technically described as an angina pectoris, accompanied by a coronary thrombosis and a posterior wall myocardial infarction. He was then in the Hotel New Yorker, and was first attended by the hotel physician and shortly thereafter by Dr. Frederick King of New York. At Dr. King's direction he was removed by stretcher and ambulance to Park East Hospital in New York where he was admitted on September 12th at approximately 12:30 o'clock p. m., He remained in that hospital until October 10, 1945, when he was brought to Toledo against Dr. King's advice (R. 63). While in the hospital and prior to September 17th, he suffered another attack similar in nature to that suffered by him on September 12th (R. 62). He was in a critical condition from September 12th to September 19th.

Prior to September 17th, the petitioner and its principal officers, Richard Edmunds, chairman of the board, Lyle C. Remdt, secretary and treasurer, J. Frank Delaplane, vice president, and, of course, Hyman Blitz, himself, the president, were fully informed of the facts related in the preceding paragraph (R. 66, 67).

No information of any kind, however, was brought to the respondent of these facts prior to September 17th,

when Hyman Blitz was approved as an insurance risk, or prior to September 19th when the policy was delivered, and no effort of any kind was made by petitioner or by its officers or by anyone on its behalf to bring these facts to the attention of the respondent (R. 66, 67); in fact, respondent first learned of these facts from the notice of claim and proof of death on or about April 18, 1946 (R. 22, 70, 72).

Dr. Brown and Mr. Marchese both testified that in approving the application and in issuing the policy they relied upon the statements and representations contained in the application, as supplemented by the results of their investigation, and both testified positively that had they known prior to the approval of the application and the issuance of the policy that Hyman Blitz had sustained a severe heart attack on or about September 12, 1945, and was confined to the hospital, they would not have approved the application or ordered the policy issued (R. 21, 22, 27).

It is significant to note that at the time Mr. Goldman delivered the policy to Mr. Remdt on September 19, 1945, he made specific inquiry of Mr. Remdt if Mr. Blitz was at home (thereby offering an opportunity to Mr. Remdt to make the disclosure of his knowledge of the then physical condition of Mr. Blitz), and that Mr. Remdt in reply merely said—"No, he is still in New York," thereby evading disclosure and deliberately leaving the impression with Mr. Goldman that Mr. Blitz was in good health and actively engaged in the business of the company (R. 67).

Mr. Blitz died on March 31, 1946, in St. Vincent's Hospital in Toledo as a result of another acute heart attack, diagnosed by his attending physician as of the same type and nature as the attack suffered by him in New York in September 1945 (R. 69).

Upon receipt of information from the notice of claim and proof of death on April 18, 1946, that Blitz had suffered heart attacks before approval of the policy, respond-

ent promptly served upon the petitioner a notice of the cancellation of the policy and tendered to petitioner the premium paid by it on September 19, 1945, with interest to the date of the tender (R. 68, 72). This tender having been refused by petitioner, the respondent brought this suit to cancel the policy.

5. The Issue

The issue presented in this case is simple and clear; whether under the terms of the application for insurance set out at pages 2-3 of this brief, and under elementary principles of equity and good faith which appertain to policies of life insurance, petitioner was guilty of fraudulent nondisclosure, in failing to apprise respondent, in the course of the negotiations for the policy, of the knowledge it had of the change in the health of the insured, rendering him uninsurable, which occurred prior to the payment of the first premium and delivery of the policy, thereby rendering the contract void at the option of respondent.

Both lower courts answered this question in the affirmative; and the trial judge in his opinion used this appropriate language (R. 92; 70 F. Supp. 188, 189):

> "The Golden Rule is an unlisted, but yet a very pertinent rule of equity that has particular application where the contract at issue is one '*uberrimae fidei*'.
>
> * * * * * *
>
> "The situation we find here is shocking to the conscience. It presents a bold attempt to exchange $4,910.00 for $40,000.00 with the defendant in possession of all the facts and the plaintiff wholly ignorant of the material fact that Mr. Blitz, on whose life the so-called 'risk' was to be taken, was at the time virtually on his death bed.
>
> "Good law is but a reflection of good conscience.

When it ceases to be such, then it is no longer good law for an enlightened society. Good conscience, as well as good law, here requires the cancellation of the contract."

ARGUMENT

1. Summary of Argument

1. The facts in the case at bar are substantially identical with those in the leading case of *Stipcich vs. Metropolitan Life Insurance Co.*, 277 U. S. 311; 48 S. Ct. 512; 72 L. Ed. 895, and the principles of law announced in that case govern this case. Both lower courts found this to be true. The trial court said (R. 90; 70 F. Supp. 188):

> "The facts of this case come squarely within the facts of *Stipcich vs. Metropolitan Life Insurance Company*, 277 U. S. 311, 48 S. Ct. 512, 72 L. Ed. 895. It is unnecessary to quote from that opinion. A study of that case will satisfy the reader that the facts of the case cannot be differentiated from the instant case. The principles of law laid down in the *Stipcich* case are controlling in the instant case."

The United States Circuit Court of Appeals in its opinion said (R. 109, 111; 166 F. 2d 65, 66):

> "There is very little difference between the *Stipcich* case and the case before us. * * * The fact that the insurance liability was to be related back to a prior date, only after the policy was delivered, does not differentiate the case from the *Stipcich* case. In both, liability was to attach, only upon delivery of the policy. * * * we, accordingly, follow the *Stipcich* case as the controlling authority."

2. The doctrine of *Erie Railroad Co. vs. Tompkins*, 304 U. S. 64, is not applicable because there are no controlling Ohio statutes, or decisions in point upon their

facts. Therefore, the rule of the *Stipcich* case applies without limitation.

Both lower courts so found. The District Court in its opinion said (R. 90; 70 F. Supp. 188):

> "No Ohio case has been cited, and the court has been unable to find one, where the facts are substantially in accord with the facts in the instant case."

The Circuit Court of Appeals in its opinion said (R. 110, 111; 166 F. 2d 66):

> "There are no Ohio statutes or decisions of the Ohio courts upon the point in question, and we, accordingly, follow the *Stipcich* case as the controlling authority."

3. Although there is no Ohio case in point in its facts, the Ohio Supreme Court has definitely recognized that the principle of good faith or of *"uberrimae fidei"* is applicable to life insurance contracts in Ohio. The District Court after pointing out that there was no Ohio case in point upon its facts said (R. 90; 70 F. Supp. 188):

> "However, in the case of *John Hancock Mutual Life Ins. Co. vs. Luzio,* 123 Ohio St. 616, at page 622, 176 N. E. 446, 449, the Supreme Court of Ohio has this to say: ' * * * But if the insured fails to disclose facts and conditions, of which he is aware, materially affecting the risk, the insured cannot recover unless the company waives forfeiture after it obtains knowledge of such undisclosed facts and conditions. *Stipcich vs. Metropolitan Life Ins. Co.,* 277 U. S. 311, 48 S. Ct. 512, 72 L. Ed. 895'."

4. The statements made by Blitz and petitioner in the application for insurance concerning the state of health of Blitz were continuing representations, and at the time the premium was paid and the policy delivered, these representations were not true; and hence, fraud having intervened, no valid contract of insurance came into existence.

There had been no meeting of the minds on the contract; the offer of petitioner had not been accepted before the intervention of petitioner's fraud. *Stipcich vs. Metropolitan Life Ins. Co., supra,* 316, 317; *Hartford Fire Insurance Co. vs. Whitman,* 75 O. S. 312, 319.

5. *Section 9391* of the General Code of Ohio, set out in petitioner's brief at page 13, is not material or applicable here. It is limited in its application by its express terms and by the construction given it by the Ohio courts to defenses founded upon breach of warranties and representations in applications for life insurance. *Cohen, Friedlander & Martin Co. vs. Mass. Mutual Life Ins. Co.,* 166 F. 2d 63, 66; *Metropolitan Life Ins. Co. vs. Howle,* 62 O. S. 204; 56 N. E. 908; *Lumpkin vs. Metropolitan Life Ins. Co.,* 75 O. App. 310; 62 N. E. 2d 189.

2. The Case of Stipcich vs. Metropolitan Life Ins. Co. Is Not Distinguishable Upon Its Facts and Is Controlling

The case of *Stipcich vs. Metropolitan Life Ins. Co., supra,* is the leading case on the question presented here. It cannot be differentiated in its facts from those of the case at bar, and the principles of law announced and applied in that case govern this case and require the result reached by the lower courts.

In the *Stipcich* case, as in the instant case, after the application was made and after the insured was examined by the company's physician, a change in his condition of health, serious in nature, developed. In the *Stipcich* case it was the reoccurrence of a duodenal ulcer. In the case at bar, it was an acute heart attack. The policy here and the policy in the *Stipcich* case contained no provisions specifically relating to the effect of a change of health and neither provided that the insured must be in good health at the time of the delivery of the policy. In the *Stipcich*

case, as here, the insured did not advise the insurance company of the facts concerning the change of health of the insured before the policy was approved or before it was delivered, or before the first premium was paid and accepted, and in that case, as here, no inquiry was made concerning the condition of the health of the insured at the time the policy was delivered and the first premium accepted.

As the Circuit Court of Appeals says in its opinion (R. 109; 166 F. 2d 65), the pertinent provisions of the two applications were substantially the same. We place them side by side for the convenience of the court.

Stipcich Case	*The Case at Bar*
"4. That the Company shall incur no liability under this application until it has been received, approved and a policy issued and delivered, and the full first premium stipulated in the policy has actually been paid to and accepted by the Company during the lifetime of the Applicant."	"2. If there has not been paid to the Company's agent the premium on the insurance herein applied for, such insurance shall not become effective until the Company has approved this application at its Home Office, the first premium has been paid and the policy delivered to me or to the owner designated therein during my lifetime; and that thereupon the insurance shall become effective upon the date of issue stated in said policy."

To say that the insurance company shall incur no "liability" until the policy is delivered, and to say that the insurance shall not become "effective" until that time, clearly is to say the same thing. The only "liability" that could be involved is the insurance liability. The fact

that in the instant case after the insurance or the insurance liability went into effect it was then, *but only then*, to be related back does not differentiate these two applications, since under each the insurance liability was to attach for the first time when the policy was delivered. On the questions material here, therefore, the provisions of the two applications are identical in meaning.

This court in the *Stipcich* case applied three controlling principles of law equally applicable here, to-wit: (1) the contract of insurance became effective only upon delivery of the policy; (2) irrespective of the stipulations of the parties, elementary principles of fair dealing and equity required a full disclosure by the insured of his change of health; and (3) the statements in the application were continuing representations up until the very moment of the delivery of the policy. This court said on page 316 of the opinion:

> "Insurance policies are traditionally contracts *uberrimae fidei* and a failure by the insured to disclose conditions affecting the risk, of which he is aware, makes the contract voidable at the insurer's option. *Carter vs. Boehm*, 3 Burrows, 1905; *Livingston vs. Maryland Insurance Co.*, 6 Cranch, 274; *McLanahan vs. Universal Insurance Co.*, 1 Pet. 170; *Phoneix Life Insurance Co. vs. Raddin*, 120 U. S. 183, 189; *Hardman vs. Firemen's Insurance Co.*, 20 Fed. 594."

and with reference to the absence of any express provision in the application of the policy requiring full disclosure by the insured of all material facts affecting the risk, this court said on page 318:

> "The obligation was not one stipulated for by the parties, but is one imposed by law as a result of the relationship assumed by them and because of the peculiar character of the insurance contract. The necessity for complying with it is not dispensed with by the failure of the insurer to stipulate in the policy for such disclosure."

The court further said on page 316 of the opinion:

"even the most unsophisticated person must know that in answering the questionnaire and submitting it to the insurer he is furnishing the data on the basis of which the company will decide whether, by issuing a policy, it wishes to insure him. If, while the company deliberates, he discovers facts which make portions of his application no longer true, the most elementary spirit of fair dealing would seem to require him to make a full disclosure. If he fails to do so the company may, despite its acceptance of the application, decline to issue a policy, *Canning vs. Farquhar*, 16 Q. B. D. 727; *McKenzie vs. Northwestern Mutual Life Insurance Co.*, 26 Ga. App. 225, or if a policy has been issued, it has a valid defense to a suit upon it. *Equitable Life Assurance Society vs. McElroy*, 83 Fed. 631, 636, 637.

Compare *Traill vs. Baring*, 4 DeG. J. & S. 318; *Allis-Chalmers Co. vs Fidelity & Deposit Co. of Maryland*, 114 L. T. 433; compare *Piedmont and Arlington Life Insurance Co. vs. Ewing*, 92 U. S. 377."

The *Stipcich* case, therefore, is directly in point and controlling on every material fact. It has been cited by innumerable courts and has found universal acceptance—as a glance at the citator will demonstrate. The rule it announced previously had been recognized by this court in the case of *Piedmont and Arlington Life Insurance Co. vs. Ewing, Admr.*, 92 U. S. 377; 23 L. Ed. 610; and by the Circuit Court of Appeals for the Seventh Circuit in *Equitable Life Assurance Society vs. McElroy, et al.* (1897) 83 Fed. 631. It has been expressly followed by the court below in *New York Life Insurance Co. vs. Gay*, 36 F. 2d 634; 48 F. 2d 595; cert. denied 284 U. S. 624.

3. The Ohio Law Is in Harmony With the Law Announced in the Stipcich Case

The principle of law which underlies the result in the *Stipcich* case is that life insurance contracts are contracts *uberrimae fidei,* and that the parties thereto, therefore, must exercise toward each other in their negotiations the utmost good faith.

Since it is conceded that there is no case in Ohio in point, our inquiry must be limited to the question whether life insurance contracts are contracts *uberrimae fidei* in Ohio.

The case of *John Hancock Mutual Life Ins. Co. vs. Luzio,* 123 O. S. 616, which was cited by the District Court in its opinion (R. 90, 91; 70 F. Supp. 188) gives a definite answer to that question, for in that recent decision the Ohio Supreme Court, Ohio's court of last resort, on page 622 said:

> "But if the insured fails to disclose facts and conditions, of which he is aware, materially affecting the risk, the insured cannot recover unless the company waives forfeiture after it obtains knowledge of such undisclosed facts and conditions. *Stipcich vs. Metropolitan Life Ins. Co.,* 277 U. S. 311, 48 S. Ct. 512, 72 L. Ed. 895."

The Ohio cases relied upon by the petitioner are not in point in their facts, and are entirely consistent with the *Stipcich* and *Luzio* cases.

In *Insurance Co. vs. Ford,* 2 O. App. 410 (decided by the Court of Appeals of Geauga County, February 4, 1914, long before the *Stipcich* case was decided), the court cites and quotes with approval (page 415) the case of *Piedmont and Arlington Life Ins. Co. vs. Ewing, Admr.,* 92 U. S. 377, referring to that case as a "leading" case. The *Ewing* case as strongly supports the proposition that life insurance contracts are contracts *uberrimae fidei,* as does the

Stipcich case, and this court in the *Stipcich* case also cited, approved and relied upon the *Ewing* case.

The court in the *Ford* case held that there was no fraudulent concealment of any material fact by the insured and that the *Ewing* case, therefore, did not apply. In the *Ford* case the premium was *prepaid;* the application made the condition of the health of the insured at the date of the application material in the event of prepayment of the premium; the insured had been examined and as a result of that examination was found to have been insurable as of that date to the satisfaction of the company; and the evidence disclosed no facts to support a claim that the company, when it approved the policy, was lacking of any fact known to the insured bearing upon the condition of his health or his insurability at the date of the application.

The result in the *Ford* case, therefore, is entirely consistent with the *Stipcich* case and with the result here; and the fact that the *Ewing* case and other like cases were cited and approved makes it probable that had the facts in the *Ford* case been as they are here, the result would have been the same as here.

The petitioner next cites and relies upon the case of *New York Life Insurance Co. vs. Clutts,* 125 O. S. 555; 182 N. E. 500, decided by the Supreme Court of Ohio on January 15, 1932, and, in particular, upon the first paragraph of the syllabus of that case.

An analysis of the facts in the *Clutts* case will demonstrate that they differ widely from the facts in the case at bar. The first paragraph of the syllabus of that case may be misleading, unless read in relation to the facts of the case. "The syllabus of a decision of the Supreme Court of Ohio states the law of Ohio, but such pronouncement must be interpreted with reference to the facts upon which it is predicated and the questions presented to and considered by the court." *Williamson Co. vs. Radich,* 128 O. S. 124, par. 1 of the syllabus.

Unfortunately, the statement of the facts preceding the opinion of the Ohio Supreme Court is very brief and leaves some important facts to inference. We, therefore, have obtained and can make available to this court a copy of the record which was before the Ohio Supreme Court.

This record shows that the insured, one George E. Krutz, made application in Louisville, Kentucky, for this policy of insurance on March 7, 1930. He was duly examined and the examination disclosed no health defects. *On March 12, 1930, he paid the first annual premium* on the policy to the company and on March 12, 1930, the same date, the company accepted the application, issued the policy, dated it as of that date and as of that date mailed it to the company's general agent at Louisville, Kentucky. On March 15th the general agent mailed it to the company's local agent at Ashland, Kentucky, for delivery to the insured, and on March 17th the local agent made manual delivery of the policy to the residence of the insured.

The delivery was made to the insured's housekeeper, who informed the local agent that the insured was ill with a headache and was resting. The agent left the policy without making any investigation concerning this illness. The evidence showed no change in the health of the insured from March 7th, the date of the application, to March 12th, the date when the application was accepted, the policy issued, dated and forwarded for delivery; and the evidence showed no lack of insurability as of March 7th, the date of the application.

The application provided, as does the application in the instant case, that in the event the premium was prepaid, then the applicant was to be entitled to the insurance if the company was satisfied that he was insurable *as of the time of the making of the application.* This provision of the application is quoted in full in the Supreme Court's opinion. The court with reference thereto said:

"we find that the contract is made in consideration of the application and the payment in advance of $56.38, the receipt of which is acknowledged on the 12th day of March, 1930."

On Sunday, March 16th, the date before the policy was taken to the home of the insured by the company's Ashland agent, the insured had suffered an attack of nose bleed and was treated by two physicians. This nose bleed, described also as a hemorrhage, was successfully stopped the same day as a result of this treatment. There is no indication that the insured had any reason to believe that the nose bleed was the occasion for any deep concern on his part, or that on March 17th he could have had any reason to think that he was withholding any material information from the company or its agent. It was not until Thursday, March 20th, that he had a second hemorrhage which then was considered of enough consequence that he was ordered hospitalized, and it was then for the first time that his trouble was diagnosed as a type of lukemia which turned out to be so serious that he died the next day, that is, March 21st.

The opinion of the Court of Appeals is not reported but is, of course, in the record which was before the Supreme Court of Ohio. This opinion reflects the fact that the cases of *John Hancock Mutual Life Ins. Co. vs. Luzio* and *Stipcich vs. Metropolitan Life Ins. Co.*, were cited and relied upon by the insurance company. The Court of Appeals found no evidence of any misrepresentation in the application and held that because of the prepayment of the premium, the policy was to be considered as delivered not later than March 15th, when it was mailed by the general agent at Louisville to the local agent at Ashland. March 15th, of course, was before the first hemorrhage which was suffered by the insured, that hemorrhage having occurred on March 16th.

The Court of Appeals held that since there could not have been any fraudulent non-disclosure by the insured as of March 15th, the *Luzio* and *Stipcich* cases had no application.

The *Clutts* case, therefore, is in point only to the extent that it, by necessary inference, recognizes the fact that life insurance contracts are contracts *uberrimae fidei*.

One other Ohio case which is relied upon by the petitioner is *Duncan vs. John Hancock Mutual Life Ins. Co.*, 137 O. S. 441. In that case the company accepted a *prepayment of the premium* which accompanied an application containing provisions as to the effect of prepayment somewhat similar, but not identical, to the provisions of the application made by petitioner here, provisions which here are not material because the premium was not prepaid.

In the *Duncan* case the insurance company also had issued a *binding receipt* in exchange for the premium paid and the company, therefore, by so doing clearly *had* made a contract. The only question before the court in the *Duncan* case was what that contract was. No question of fraudulent concealment or any fraud of any kind on the part of the insured was involved and the case cannot be considered inconsistent with the *Stipcich, Gay* and *Luzio* cases, or as remotely bearing upon the important question here, *i.e.*, whether in Ohio life insurance contracts are contracts *uberrimae fidei*.

The *Duncan* case was clarified and distinguished in the later case of *Leube vs. The Prudential Ins. Co. of America*, 147 O. S. 450.

It is apparent, therefore, that the lower courts were correct in finding and holding that no Ohio case was in point or controlling, and that, therefore, the rule of the *Stipcich* case applied here without limitation. The lower courts were also fortified in their decision by the fact that

the Ohio Supreme Court has definitely approved the principle that life insurance contracts require the utmost good faith upon the part of both parties.

4. Other Authorities Cited By Petitioner Are Not in Point

Under the heading "General Authorities and Decisions From Other Jurisdictions," petitioner's brief cites the cases of

Ames vs. New York Life Ins. Co. (Minn. 1922), 191 N. W. 274.

New York Life Ins. Co. vs. Moats (9th Cir. 1913), 207 Fed. 481.

Grier vs. Mutual Life Ins. Co. (N. C. 1903), 44 S. E. 28.

Watson vs. Metropolitan Ins. Co. (Pa. 1941), 21 Atl. 2d 503.

The *Ames* case was decided by the Supreme Court of Minnesota long before the *Stipcich* case. In that case the illness of the insured had occurred after the application was accepted and the policy issued, contrary to the fact here. The court recognized the duty of applicants for life insurance policies to make full disclosure of all material facts while negotiations are pending between the parties. It will be noted that in the part of the opinion, quoted on page 19 of petitioner's brief, the court said:

> "Unlike most of the cases in which the doctrine has been asserted, the negotiations between the parties were no longer pending * * *."

The court, therefore, considered that the acceptance by the company of the application and its issuance of the policy ended the negotiations. In the instant case the serious illness of Hyman Blitz occurred even before the application was accepted and before the policy was issued. The case, therefore, is not in point.

The *Moats* case also was decided before the *Stipcich* case. We fail to see how under any theory the reasons given by the court for its decision in the *Moats* case can be reconciled with the *Stipcich* case. In the *Moats* case the premium had been prepaid, which fact, by reason of the terms of the application, gave foundation for an argument that the parties had contracted on the basis of conditions as they existed as of the date of the application. The *Moats* case, therefore, in any event, presents an entirely different factual situation.

In the *Grier* case, decided by the Supreme Court of North Carolina in 1903, the insured had given a "binding receipt" at the time the application was made, through which the agent, acting for the insured, agreed that the insurance should be in force from that date subject to the then insurability of the insured. A contract, therefore, came into being as of that date, contrary to the fact here. The insured's illness occurred after that date but before the policy was delivered. The policy contained a good health clause. The Supreme Court of Georgia held that "in the absence of fraud" the delivery of the policy was a waiver of the benefits of the good health clause. This holding, by the way, is contrary to the great weight of authority and contrary to the Ohio law. The case obviously is not of any consequence in this case.

In the *Watson* case there was no fraudulent concealment of any kind involved. After the policy was issued and tender of it had been made to the insured, insured asked for some additional time in which to pay the premium, which was granted to him. A week or so later when he paid the premium and accepted the policy he was suffering from a cold or bronchial asthma of which the agent of the company was informed at the time of the delivery. The opinion in the *Watson* case, at pages 509-510 of the opinion, cites the *Stipcich* case with approval.

5. Fallacies in Petitioner's Argument

The entire burden of the argument advanced by the petitioner proceeds upon the fallacious proposition that its own application for the policy in and of itself gave rise to some contract between the respondent and petitioner. In making the argument, the petitioner necessarily disregards utterly the fact that the application was nothing more than its own request for a policy unsupported by any consideration and, therefore, at best nothing more than a revocable offer which was submitted by petitioner to respondent.

Had the petitioner tendered *prepayment* of the premium and had that tender been accepted by the respondent, there might have been some basis for its claim that there was a contract between the parties prior to the delivery of the policy. The authorities even differ on that proposition. *New York Life Ins. Co. vs. Gay, supra.* That, however, was not the fact here where the premium was not prepaid, and where fraud intervened before the premium was paid and the policy delivered.

The petitioner points with emphasis to the statement in the application that *after* the policy becomes effective by delivery, it shall *thereupon* "become effective upon the date of issue stated in the policy" and to the fact that the policy when delivered bore a date prior to the date of the application, and from these circumstances argues that in some manner that there came into being a contract as of the date of the application or as of the date of the policy.

Such an argument contains the same fundamental fallacy—it assumes that the application is the contract. The application still was only an offer not binding the respondent in any respect without regard to any of its provisions until accepted. That offer was not accepted by the very terms of the application until the policy was delivered, and the petitioner, having procured the consummation of

the contract by fraud, cannot now rely upon any provision of that contract without regard to any date which it may bear, to escape the consequences of its own fraud. The policy so dated is the very thing which is tainted by petitioner's own fraud.

The petitioner also argues that the respondent collected a premium for the period from August 10th, the date of the policy, to September 19th, the date of its delivery, asserting in effect that the petitioner will not have been fairly treated if it received no coverage for that period.

Such an argument overlooks the fact that the acceptance of the premium by the respondent was procured by the fraud of petitioner, and that if this fraud had not intervened the premium would not have been accepted and the petitioner would have been in exactly the same position that it will be in when the premium with interest is returned to it. That argument also overlooks the fact that the insurance involved was not insurance against a change in health of the prospective insured, but was insurance against his death, which had not occurred, of course, when the policy was delivered. It also overlooks the fact that the only purpose in predating the policy was to give the petitioner the benefit of a lower premium (R. 28).

Since Hyman Blitz, for insurance purposes, was to be considered as a year younger as of August 10th than he would have been as of the date of the application or the date of the policy, the difference in annual premium amounted to approximately Four Hundred Dollars and the fact was, therefore, that the respondent on September 19th was paid several hundred dollars *less than it would have been paid had the policy been dated as of one of those later dates.*

This practice is customary and common in the negotiation of life insurance contracts. See *Couch on Insurance,*

Vol. 6, page 4799, Section 1330, and *Henry vs. Reich*, 80 O. App. 185. The syllabus of the last cited case is as follows:

> "Where an applicant for life insurance requests in his application that the policy take effect as of a date prior to the application, for the purpose of taking advantage of a lesser age and consequent lesser premium; the policy is delivered to applicant, the first annual premium is paid by cognovit note and applicant becomes insured, all on a date subsequent to the application; and the policy reads that the first annual premium was due on the requested effective date for a period ending one year from such date; there is no failure of consideration for the note or fraud in its induction on the ground that the applicant was not insured from the time the first annual premium became due, but was insured only from the time of delivery of the policy."

6. Ohio General Code, Section 9391 Is Not Applicable

The petitioner argues in its brief that the provisions of *Ohio General Code*, Section 9391, having reference to false answers to interrogatories in insurance applications and defenses based upon such applications is applicable and that it is of some assistance to the petitioner in its claim of right to recover under this policy.

The section is quoted in full on page 13 of petitioner's brief and we will not repeat it here. It is limited in its application to positive or affirmative misrepresentations made in the application. It has no reference or application to a defense based upon a fraudulent nondisclosure of material facts which came to the attention of the insured after the application was made.

Even though the statute could have some application, it is perfectly evident that at the time the application was approved in the home office of the respondent on Septem-

ber 17, 1945, and at the time of the delivery of the policy on September 19, 1945, the representation in the application that Hyman Blitz had not had at any time "pain, pressure or discomfort of the chest, shortness of breath, palpitation or any disease of the heart," was utterly false and was known to the insured to be false, and if this representation is to be considered as having been made either as of September 17th or September 19th, as the *Stipcich* and other cases have said, then it was a misrepresentation which was wilfully false, fraudulent and was a misrepresentation of the material fact and the evidence establishes beyond any doubt that the policy would not have been issued if the company had been informed of the true facts. It follows, therefore, that even if Section 9391 were applicable, respondent's proof fully satisfied the requirements of that statute.

CONCLUSION

It is submitted that the courts below have reached the right result in this case. There are no special or important reasons for the granting of this petition; no conflicts of decisions appear and no controlling local law is cited at variance with the decisions of the lower courts.

The case is ruled by the decision of this court in the *Stipcich* case. The petition, therefore, should be denied.

Respectfully submitted,

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